

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14177

Reg. Dist. No.

14187

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Luzen Anne</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Smithville</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Queen Anne</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sudlersville</u> d. STREET ADDRESS <u>1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Harry</u> Middle <u>Gaylor</u> Last <u>Anthony</u>				<b>4. DATE OF DEATH</b> Month <u>12</u> Day <u>30</u> Year <u>1958</u>											
<b>5. SEX</b> <u>male</u>		<b>6. COLOR OR RACE</b> <u>white</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>June 16-1884</u>		<b>9. AGE</b> (In years last birthday) <u>74</u> yrs.		<b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u>		<b>IF UNDER 24 HRS.</b> Hours <u>  </u> Min. <u>  </u>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Painter</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>House Painter</u>				<b>11. BIRTHPLACE</b> (State or foreign country) <u>Md.</u>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>US</u>			
<b>13. FATHER'S NAME</b> <u>Henry Anthony</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>Sarah Sylvester</u>									
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u>				<b>16. SOCIAL SECURITY NO.</b> <u>218-20-8799</u>				<b>17. INFORMANT</b> Address <u>Mrs Beulah Anthony Sudlersville</u>							
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fractured Skull - broken leg</u> DUE TO (b) <u>812X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>  </u>												INTERVAL BETWEEN ONSET AND DEATH <u>at once</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>															
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>Motor vehicle and pedestrian</u>											
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <u>  </u> o. m. <u>12/30/58</u> p. m.				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>				<b>20f. (City or town)</b> <u>Sudlersville</u>		<b>(County)</b> <u>Q.A.</u>		<b>(State)</b> <u>Md.</u>	
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> . <b>Inspection</b> <input type="checkbox"/> . <b>Inquiry</b> <input type="checkbox"/> . and find that death resulted from: <b>Natural causes</b> <input type="checkbox"/> . <b>Accident</b> <input checked="" type="checkbox"/> . <b>Suicide</b> <input type="checkbox"/> . <b>Homicide</b> <input type="checkbox"/> . <b>Undetermined cause</b> <input type="checkbox"/> .															
<b>ACTUAL SIGNATURE</b> <u>W. Henry Fisher</u> M.D.						<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>						<b>DATE SIGNED</b> <u>12/30-58</u>			
<b>EXAMINER'S NAME (Type)</b>						<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>						<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>			
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>				<b>22b. DATE THEREOF</b> <u>Jan. 3, 1958</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Church Hill Cem.</u>				<b>22d. LOCATION (City, town, or county)</b> <u>Church Hill Md.</u>				<b>(State)</b>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Edward Vellor Milington Md.</u>						<b>ADDRESS</b>				<b>24a. REC'D BY REGISTRAR</b> DATE <u>JAN 5 '59</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur L. Hume</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE DEPARTMENT OF HEALTH  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2025

Name of Deceased		Sex		Age	
Date of Death		Time of Death		Place of Death	
Cause of Death		Manner of Death		Occupation	
Signature of Examiner		Signature of Coroner		Signature of Physician	
Date of Report		Time of Report		Place of Report	

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 14188 CERTIFICATE OF DEATH

Reg. Dist. No. 14178

1. PLACE OF DEATH a. COUNTY <u>Queen Anne</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Stevensville, Md</u>				c. LENGTH OF STAY IN 1b <u>2 1/2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Sellies</u> Middle <u>Bailey</u> Last <u>Bailey</u>				4. DATE OF DEATH Month <u>12</u> Day <u>4</u> Year <u>1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Col</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1892</u>	
9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Waterman</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Charles Bailey</u>				14. MOTHER'S MAIDEN NAME <u>Lena Nixon</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>WWI</u>				16. SOCIAL SECURITY NO. <u>  </u>		17. INFORMANT Address <u>Harrison Bailey, Stevensville, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 d.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>58</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Oct.</u> , 19 <u>58</u> , to <u>Dec</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Dec 2</u> , 19 <u>58</u> , and that death occurred at <u>1:30</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Irvin G. Hoyt</u> M.D.				ADDRESS (Street, city or town, state) <u>Queenstown, Md.</u> DATE SIGNED <u>12/8/58</u>			
PHYSICIAN'S NAME (Type) <u>Irvin G. Hoyt MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-8-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bathsrock Cam</u>		22d. LOCATION (City, town, or county) (State) <u>Stevensville Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James B. Dashiell, Easton, Md</u> ADDRESS <u>  </u>				24a. REC'D BY REGISTRAR <u>  </u> DATE <u>DEC 10 '58</u>		24b. REGISTRAR'S SIGNATURE <u>  </u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14179

14183

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>QUEEN ANNE'S</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>PENNA.</b> b. COUNTY <b>LANCASTER</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL QUEENSTOWN</b>				c. LENGTH OF STAY IN 1b <b>30 days</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <b>23 HAGER STR.</b>			
3. NAME OF DECEASED (Type or print) First <b>IRENE</b> Middle <b>C.</b> Last <b>DEAN</b>				4. DATE OF DEATH Month <b>DEC</b> Day <b>24</b> Year <b>1958</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>DEC. 4 1887</b>	
9. AGE (In years last birthday) <b>71</b> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>PENNA.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>William Crumbling</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Wolf</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	
16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>DORIS A. HITCH</b>		Address <b>521 MANOR RD. GLEN BURNIE, Md.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Coronary Occlusion</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. [b] _____ DUE TO [c] _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>Suddenly</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>W. Henry Fisher</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>W. HENRY FISHER</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, or REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>DEC. 27, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Conestoga Memorial Park</b>		22d. LOCATION (City, town, or county) (State) <b>LANCASTER Co. PENNA.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James H. Butler Jr. of Butler Bros., Centerville, Maryland.</b>				24a. REC'D BY REGISTRAR DATE <b>DEC 29 1958</b>		24b. REGISTRAR'S SIGNATURE <b>James H. Butler</b>	





## 14190 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Queen Anne</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Millington</u> <u>Crumpton</u> adult life				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crumpton</u> <u>Millington, Md.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Paradotown</u> RFD				e. STREET ADDRESS <u>Paradotown</u> RFD		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Wm. Henry Elliott</u>				4. DATE OF DEATH <u>Dec. 2, 1958</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 15, 1881</u>	9. AGE (In years last birthday) yrs. <u>76</u>	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>laborer</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles</u> <u>UNKNOWN</u> <u>Elliott</u>				14. MOTHER'S MAIDEN NAME <u>Harriett Young</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>217-30-7590</u>		17. INFORMANT <u>Mary Lee</u> <u>Millington, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> <u>422.1</u> DUE TO Arterio Sclerotic Vascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>unknown</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April</u> , 19 <u>58</u> to <u>Dec. 2</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Dec. 2</u> , 19 <u>58</u> , and that death occurred at _____ M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert W. Farr, M. D.</u>				ADDRESS (Street, city or town, state) <u>Chestertown, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Robert W. Farr, M. D.</u>				DATE SIGNED <u>Dec 5 '58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/6/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ewingtown Cem. Queen Anne Co. nr. Church Hill Md.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Kenneth Walling</u>				ADDRESS <u>Chestertown, Md.</u>		24a. REC'D BY REGISTRAR <u>DEC 5 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# WESTINGHOUSE STATE OF NEW YORK DEPARTMENT OF HEALTH CERTIFICATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

NAME OF DECEASED

<p>1. Name of deceased</p>	
<p>2. Sex</p>	
<p>3. Age</p>	
<p>4. Date of death</p>	
<p>5. Place of death</p>	
<p>6. Cause of death</p>	
<p>7. Signature of physician</p>	
<p>8. Signature of registrar</p>	



## 14191 CERTIFICATE OF DEATH

14181

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Queen Anne</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Centreville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Centreville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Route 3, Box 122</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Thomas</u> Middle <u>Gould</u> Last <u></u>		4. DATE OF DEATH Month <u>12</u> Day <u>15</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 8, 1885</u>
9. AGE (In years last birthday) <u>73</u> yrs.		10. IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>tenant</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Benjamin Gould</u>		14. MOTHER'S MAIDEN NAME <u>MARY E Green</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>Thomas F. Gould Jr. Centreville, Md.</u>		Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Thrombosis in left hemi-</u> DUE TO <u>plegia</u> (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u> <u>4 mo.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Nov.</u> , 19 <u>55</u> , to <u>Dec.</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Dec. 10</u> , 19 <u>58</u> , and that death occurred at <u>7:30</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Irvin G. Hoyt</u> M.D.		ADDRESS (Street, city or town, state) <u>Queen Anne, Md.</u> DATE SIGNED <u>12/18/58</u>	
PHYSICIAN'S NAME (Type) <u>Irvin G. Hoyt MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12/18/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Gould Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Centreville Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>James S. Dashiell, Easton, Md.</u>		ADDRESS <u></u>	
24a. REC'D BY REGISTRAR <u>DEC 22 '58</u>		24b. REGISTRAR'S SIGNATURE <u>C. S. Kious</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased _____		Date of Death _____	
Sex _____		Age _____	
Usual Residence _____		Date of Birth _____	
Cause of Death _____		Place of Death _____	
Signature of Physician _____		Signature of Registrar _____	
Date of Signature _____		Date of Signature _____	
Signature of Coroner _____		Signature of Medical Examiner _____	
Date of Signature _____		Date of Signature _____	
Signature of Burial Officer _____		Signature of Interment Officer _____	
Date of Signature _____		Date of Signature _____	

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON

RECEIVED

DATE

TIME

BY

OFFICE

FILE

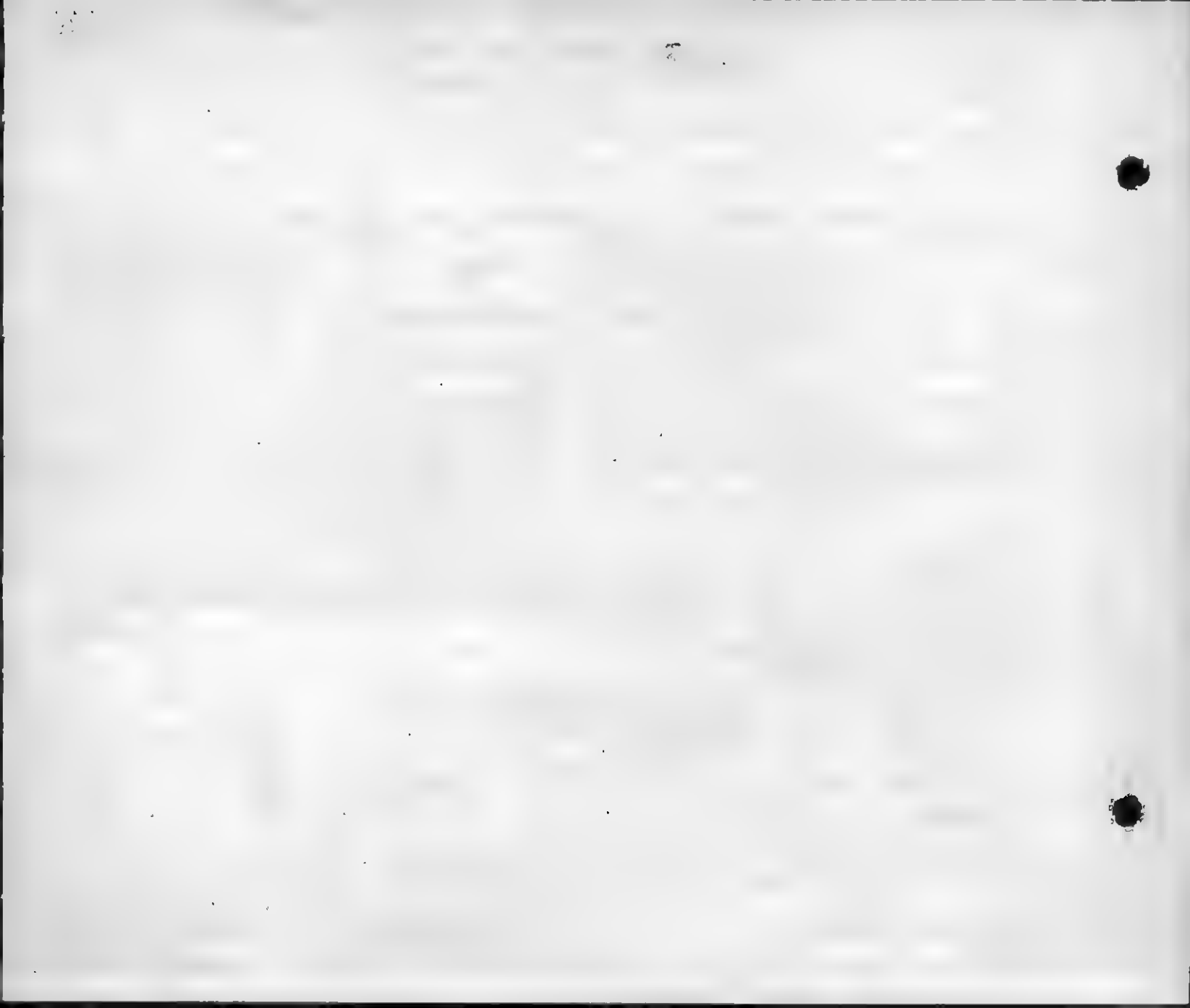
## 14192 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Queen Anne's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesler</u>		c. LENGTH OF STAY IN 1b <u>all about 2 1/2 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>Domestic</u>	
3. NAME OF DECEASED (Type or print) <u>FRANK</u> First <u>HARRISON</u> Middle <u>LEE</u> Last		4. DATE OF DEATH Month <u>Dec</u> Day <u>22</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 27 - 1884</u>
9. AGE (In years last birthday) <u>74</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Waterman</u>	
11. BIRTHPLACE (State or foreign country) <u>Delaware</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Francis Lee</u>		14. MOTHER'S MAIDEN NAME <u>Ruth Ann Sperry</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-25-9836</u>	
17. INFORMANT <u>Marion Lee</u>		Address <u>Chesler, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute coronary thrombosis</u> <u>4x0.1</u> DUE TO (b) <u>hypertensive cardio-vascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Arteriosclerosis general + cerebral</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Dec 22, 1958</u> <u>about 5 years</u> <u>about 5 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>th</u>		20f. (City or town) (County) (State) <u>md</u>	
21. I certify that I attended the deceased from <u>May 10</u> , 19 <u>58</u> , to <u>Dec 22</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Dec. 22</u> , 19 <u>58</u> , and that death occurred at <u>5:10 A</u> . M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Theodor Sattelmaier</u>		ADDRESS (Street, city or town, state) <u>Stevensville</u>	
PHYSICIAN'S NAME (Type) <u>Theodor SATTELMAIER M.D.</u>		DATE SIGNED <u>Dec 23, 1958</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Dec 24-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Stevensville</u>	22d. LOCATION (City, town, or county) (State) <u>Stevensville Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edmund Bantz</u>		ADDRESS <u>Factor Bros Chesler Md</u>	
24a. REC'D BY REGISTRAR DATE <u>Dec 23</u>		24b. REGISTRAR'S SIGNATURE <u>W. L. Moore</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

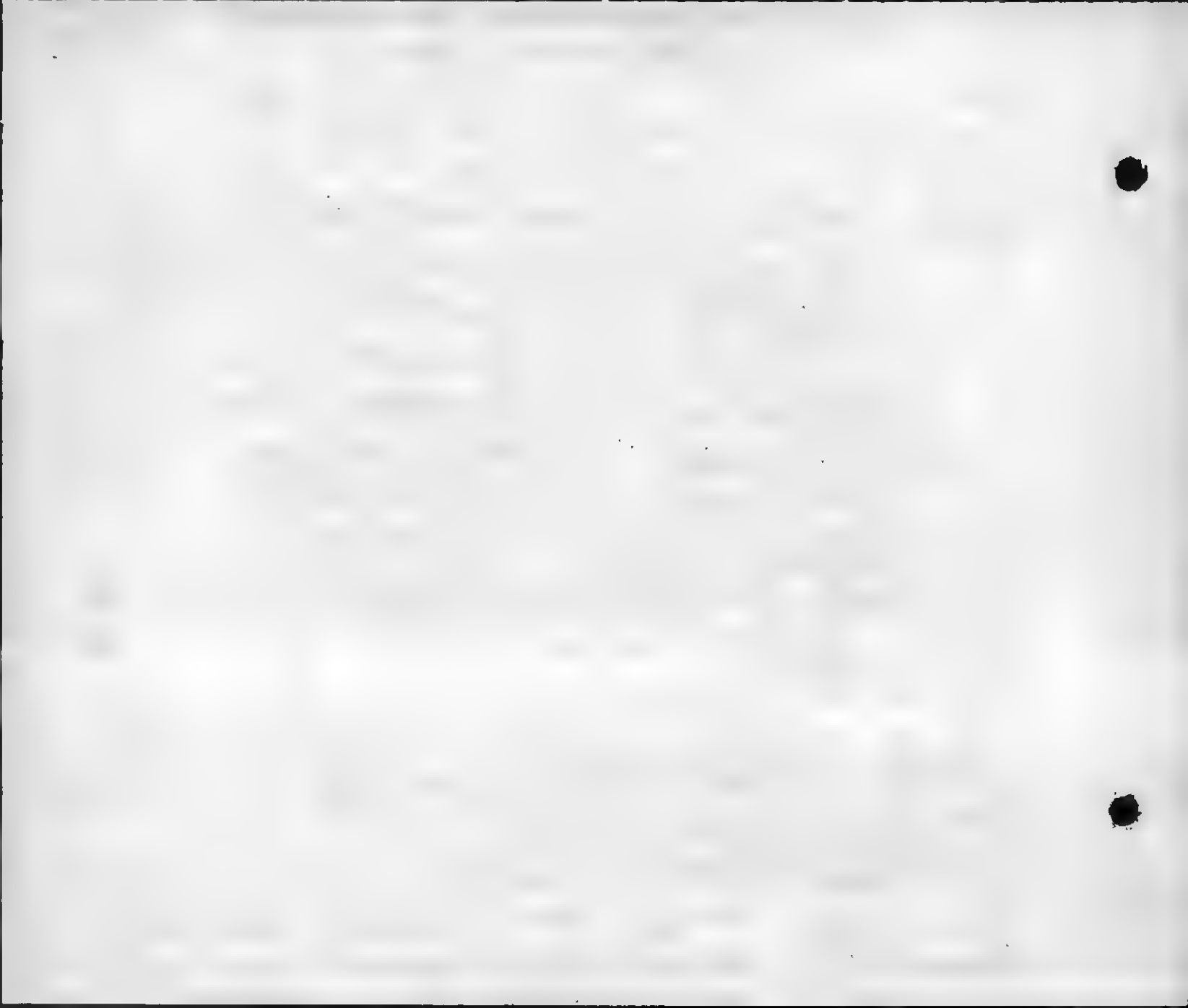


14184

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Queen Anne's</u>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived - If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Centreville</u>		c. LENGTH OF STAY IN 1b <u>Worthy life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Centreville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>1 Burrowsville</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print)		First <u>ARPHIE</u>	Middle <u>G.</u>	Last <u>REILLY</u>	4. DATE OF DEATH Month <u>Dec</u> Day <u>17</u> Year <u>1958</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Caucasoid</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>July 14-1897</u>	9. AGE (In years last birthday) <u>61 yrs.</u>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lumberman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Stevensville Md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Philip Reilly</u>		14. MOTHER'S MAIDEN NAME <u>Rebecca Reilly</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-30-8026</u>		17. INFORMANT <u>Ethel R Johnson daughter Centerville Md</u> Address <u>PFA.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic valvular disease of the heart</u> <u>421.4</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Atherosclerosis</u> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>a.m.</u> Month <u>Jan</u> Day <u>1</u> Year <u>1956</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Centerville Md</u>	
20f. (City or town) <u>Centerville Md</u>		(County) <u>Queen Anne's</u>		(State) <u>Md</u>	
21. I certify that I attended the deceased from <u>Jan 1</u> , 19 <u>56</u> , to <u>Dec 17</u> , 19 <u>58</u> . That I last saw the deceased alive on <u>Dec 15</u> , 19 <u>58</u> , and that death occurred at <u>Centerville Md</u> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>H.F.McPherson</u>		M.D. <u>Centerville Md</u>		DATE SIGNED <u>12/19/58</u>	
PHYSICIAN'S NAME (Type) <u>H.F.McPherson</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>Aug 20-1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Burrowsville</u>	
22d. LOCATION (City, town, or county) <u>Centerville Maryland</u>		(State) <u>Md</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Baughman</u>		ADDRESS <u>Centerville Md</u>		24a. REC'D BY REGISTRAR <u>EC 23 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>S. S. Hunt</u>					





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 14194 CERTIFICATE OF DEATH

Reg. Dist. No. 14185

1. PLACE OF DEATH a. COUNTY <b>Queen Anne</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Kent.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sudlersville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>St'll Pond</b> 14X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Walraven Nursing Home</b>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <b>CARRIE</b> First Middle Last <b>SCHOFIELD</b>		4. DATE OF DEATH Month <b>December</b> Day <b>5</b> Year <b>1958</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>February 22, 1881</b>
9. AGE (In years last birthday) <b>77</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Still Pond, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John H. Harding</b>		14. MOTHER'S MAIDEN NAME <b>Caroline Scotten</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>None</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Julian O. Scofield,</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Poste Cardiac Dissection</b> <b>422-1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic myocardiopathy</b> (c) <b>General Arteriosclerosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Psychic</b>			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>20</b>	
20c. TIME OF INJURY Hour a. p. m. <b>20</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Aug 1956</b> to <b>Dec 5, 1958</b> , that I last saw the deceased alive on <b>Dec 4, 1958</b> , and that death occurred at <b>2 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>101 Whitehall Rd. Sudlersville, Md.</b> DATE SIGNED <b>12/6/58</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Dec. 8, 1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Georgetown Cem.</b>
22d. LOCATION (City, town, or county) (State) <b>Georgetown, Md.</b>		23. FUNERAL DIRECTOR'S SIGNATURE <b>Edward F. Hollows, Millington, Md.</b>	
24a. REC'D BY REGISTRAR <b>DEC 10 58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Pruss</b>	

CERTIFICATE OF DEATH

1185

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES J. JONES		35		M		W		JAN 15 1880		NEW YORK	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH	
100 MAIN ST. BOSTON		LABORER		HEART DISEASE		NATURAL		JAN 20 1915		BOSTON	
FATHER		MOTHER		BROTHERS		SISTERS		MARRIED		EDUCATION	
JAMES J. JONES		MARY J. JONES		JOHN J. JONES		ELIZABETH J. JONES		YES		HIGH SCHOOL	
DATE OF MARRIAGE		NAME OF MINISTER		NAME OF CHURCH		NAME OF PHYSICIAN		NAME OF BURIAL PLACE		NAME OF FUNERAL HOME	
JAN 15 1910		JAMES J. JONES		ST. MARY'S CHURCH		JAMES J. JONES		ST. MARY'S CEMETERY		JAMES J. JONES	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESSES		SIGNATURE OF MINISTER		SIGNATURE OF PHYSICIAN		SIGNATURE OF BURIAL PLACE		SIGNATURE OF FUNERAL HOME	
DECEASED'S SIGNATURE		WITNESSES' SIGNATURE		MINISTER'S SIGNATURE		PHYSICIAN'S SIGNATURE		BURIAL PLACE'S SIGNATURE		FUNERAL HOME'S SIGNATURE	
DECEASED'S ADDRESS		WITNESSES' ADDRESS		MINISTER'S ADDRESS		PHYSICIAN'S ADDRESS		BURIAL PLACE'S ADDRESS		FUNERAL HOME'S ADDRESS	
100 MAIN ST. BOSTON											
DECEASED'S PHONE		WITNESSES' PHONE		MINISTER'S PHONE		PHYSICIAN'S PHONE		BURIAL PLACE'S PHONE		FUNERAL HOME'S PHONE	
DECEASED'S RELIGION		WITNESSES' RELIGION		MINISTER'S RELIGION		PHYSICIAN'S RELIGION		BURIAL PLACE'S RELIGION		FUNERAL HOME'S RELIGION	
CATHOLIC											
DECEASED'S POLITICAL PARTY		WITNESSES' POLITICAL PARTY		MINISTER'S POLITICAL PARTY		PHYSICIAN'S POLITICAL PARTY		BURIAL PLACE'S POLITICAL PARTY		FUNERAL HOME'S POLITICAL PARTY	
DEMOCRAT											
DECEASED'S OCCUPATION		WITNESSES' OCCUPATION		MINISTER'S OCCUPATION		PHYSICIAN'S OCCUPATION		BURIAL PLACE'S OCCUPATION		FUNERAL HOME'S OCCUPATION	
LABORER											
DECEASED'S EDUCATION		WITNESSES' EDUCATION		MINISTER'S EDUCATION		PHYSICIAN'S EDUCATION		BURIAL PLACE'S EDUCATION		FUNERAL HOME'S EDUCATION	
HIGH SCHOOL											
DECEASED'S MARRIAGE		WITNESSES' MARRIAGE		MINISTER'S MARRIAGE		PHYSICIAN'S MARRIAGE		BURIAL PLACE'S MARRIAGE		FUNERAL HOME'S MARRIAGE	
YES											
DECEASED'S DEATH		WITNESSES' DEATH		MINISTER'S DEATH		PHYSICIAN'S DEATH		BURIAL PLACE'S DEATH		FUNERAL HOME'S DEATH	
JAN 20 1915											
DECEASED'S PLACE		WITNESSES' PLACE		MINISTER'S PLACE		PHYSICIAN'S PLACE		BURIAL PLACE'S PLACE		FUNERAL HOME'S PLACE	
BOSTON											
DECEASED'S STATE		WITNESSES' STATE		MINISTER'S STATE		PHYSICIAN'S STATE		BURIAL PLACE'S STATE		FUNERAL HOME'S STATE	
MASSACHUSETTS											
DECEASED'S COUNTRY		WITNESSES' COUNTRY		MINISTER'S COUNTRY		PHYSICIAN'S COUNTRY		BURIAL PLACE'S COUNTRY		FUNERAL HOME'S COUNTRY	
UNITED STATES											

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14195 CERTIFICATE OF DEATH

Reg. Dist. No.

14187

1. PLACE OF DEATH a. COUNTY <u>Queen Anne's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Mellington (Pratton)</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X RFD Centerville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sallie Wynn Nursing Home</u>		d. STREET ADDRESS <u>1 Beersville</u>	
3. NAME OF DECEASED (Type or print) <u>CLARENCE H WILSON</u>		4. DATE OF DEATH Month <u>Dec</u> Day <u>29</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr 5-1873</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		9b. KIND OF BUSINESS OR INDUSTRY <u>farm owner</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>farm owner</u>	
11. BIRTHPLACE (State or foreign country) <u>Queen Anne's Co Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph Wilson</u>		14. MOTHER'S MAIDEN NAME <u>do not know - Hester?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Edward Wilson</u>		Address <u>1012 Hartford St Washington Del</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.1</u> DUE TO <u>Cerebral Hemorrhage</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis</u> (c) <u>Chronic myocardial</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Stroke</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>no</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <u>Dec 29</u> Hour <u>19</u> p. m.		20d. INJURY OCCURRED <u>While at work</u> <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec 10, 1958</u> , to <u>Dec 29, 1958</u> , that I last saw the deceased alive on <u>Dec 24, 1958</u> , and that death occurred at <u>6 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>C. W. Peleccy</u> M.D.		DATE SIGNED <u>Dec 14/30/58</u>	
PHYSICIAN'S NAME (Type) <u>Frederick</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>	22b. DATE THEREOF <u>Jan 2 - 1959</u>	22c. NAME OF CEMETERY OR CREMATORY— <u>Beersville</u>	22d. LOCATION (City, town, or county) (State) <u>Beersville in Centerville Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Thomas Prater, Jr. Beersville</u>		24a. REC'D BY REGISTRAR <u>Jan 7 '59</u>	
ADDRESS <u>Centerville Md</u>		24b. REGISTRAR'S SIGNATURE <u>C. W. Peleccy</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

